June 21, 2018

ECRI Institute's

Top 10 Patient Safety Concerns

for Healthcare Organizations

2018

ECRI Institute PSO 10 years

Learning Objectives

- Participants will be able to:
  - Describe why ECRI Institute created its list of Top 10 Patient Safety Concerns.
  - Use the list to help review patient safety concerns in their own organization.
  - Discuss ECRI Institute's Top 10 Patient Safety Concerns for 2018.

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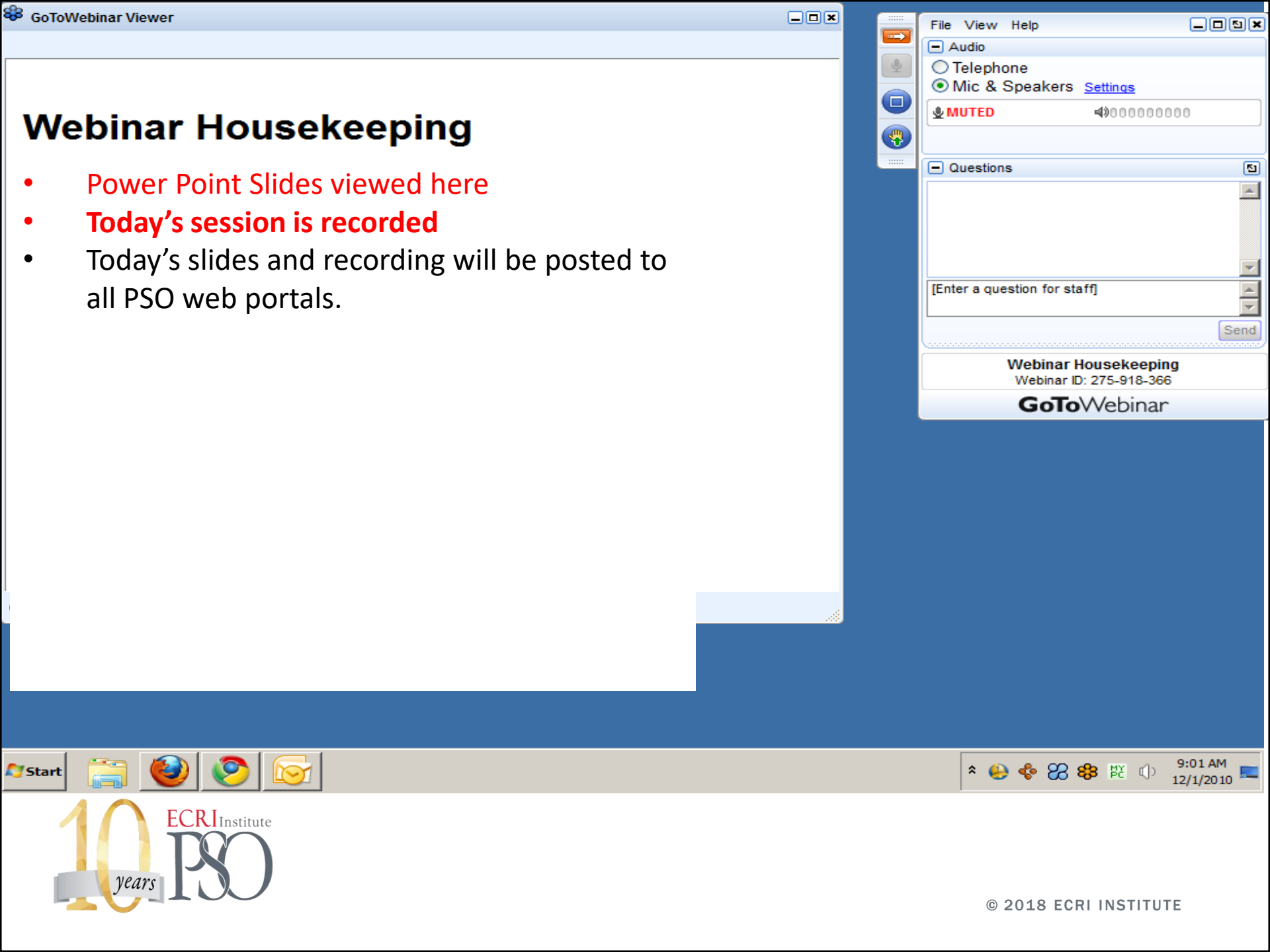
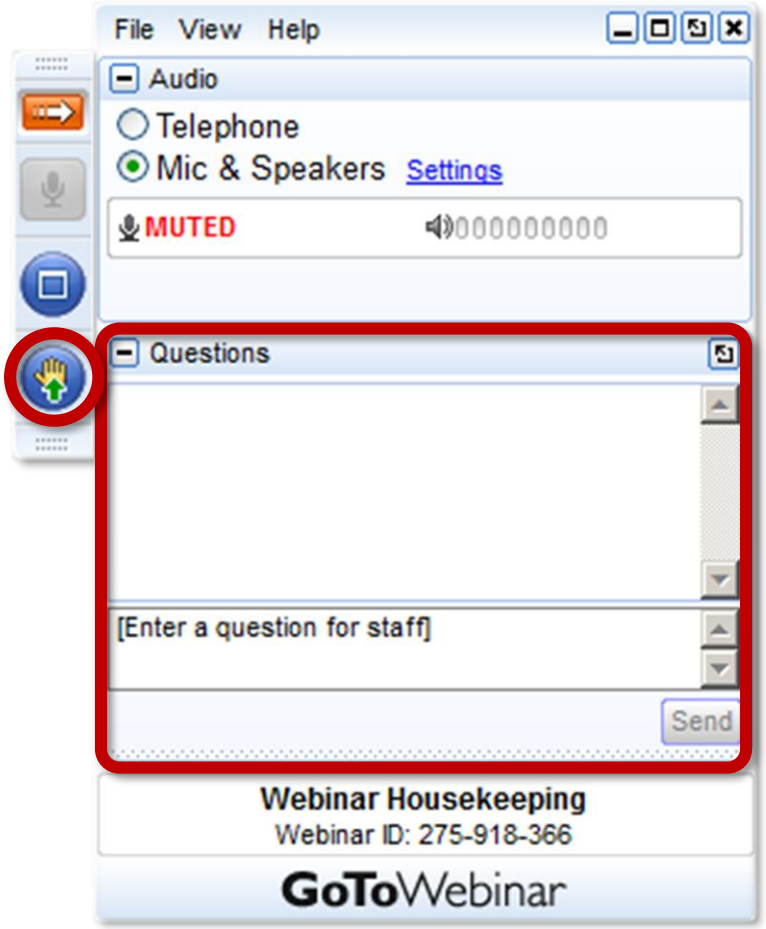


How to Ask Questions



Remember…

- Please submit your text questions and comments using the Questions Panel

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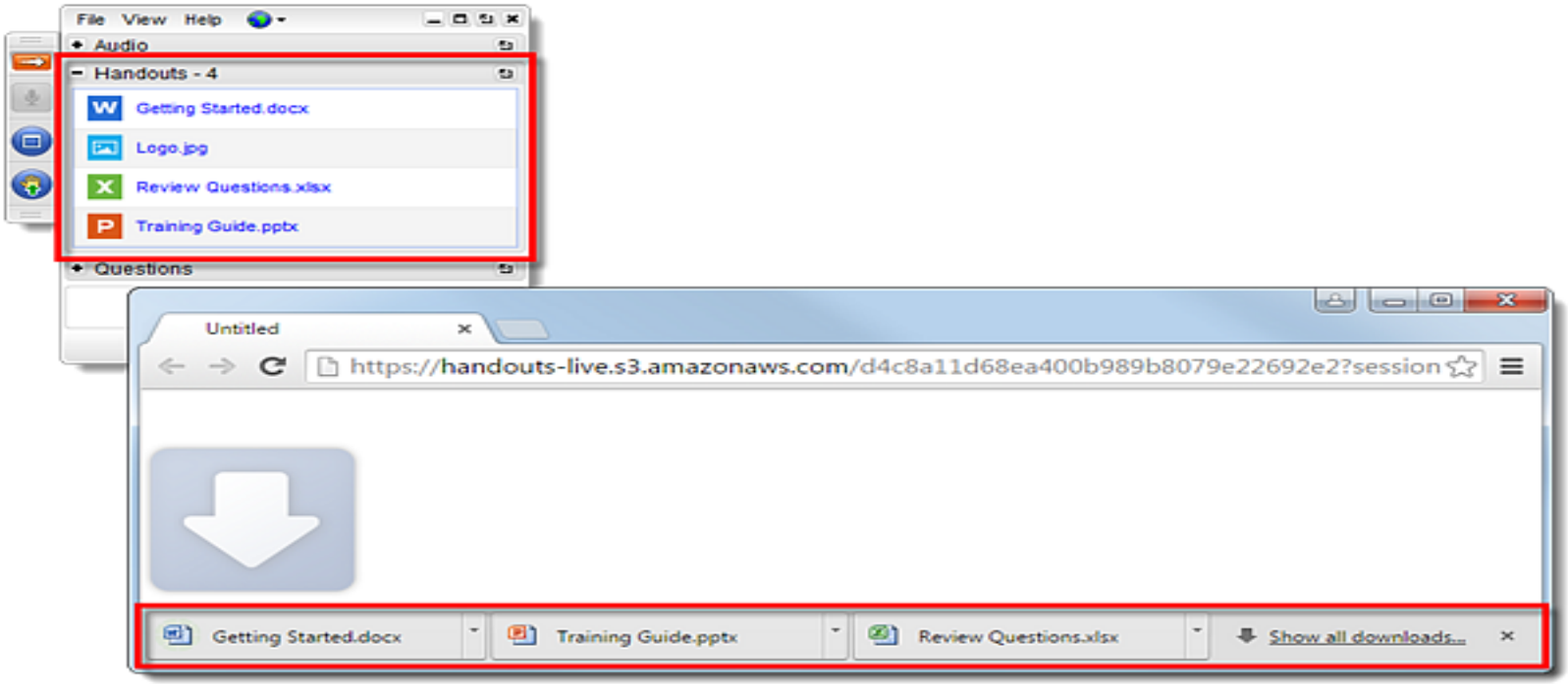
2. Their default web browser will automatically launch and open a blank page, and the handout file will automatically start downloading.
3. Attendees can then click the downloaded file to open or save it.



This activity has been approved for 1.0 California State Nursing contact hour by the provider, Debora Simmons, who is approved by the California Board of Registered Nursing, Provider Number CEP 13677.

All faculty members involved in ECRI Institute's June 21, 2018 live webinar, *Top 10 Patient Safety Concerns for Healthcare Organizations* have disclosed in writing that they do not have any relevant conflicts or financial affiliations.

To qualify for credit:

Credit will only be issued to attendees that are *individually* registered *and* attend the *entire* program. Each individual participant must logon prior to the start of the program and remain on the line for the entirety of the program. This is how individual timed attendance is verified. In addition, you must complete an attestation survey included in the post webinar evaluation at the conclusion of the webinar. Once all that information is verified, a certificate will be e-mailed to you within 60 days of today's program.

ECRI Institute's
Top 10 Patient Safety Concerns

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ECRI Institute PSO

- One of the first federally certified patient safety organizations (PSOs)
- Collecting event reports since 2009
- Over 2 million event reports submitted by end of 2017
- Top 10 report is one way we share our findings

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How We Created the Top 10 List

- We synthesized data from:
  - Our analysts' routine review of events in the ECRI Institute PSO database
  - Topics reflected in PSO members' recent root-cause analyses and research requests
  - Topics reflected in the ECRI Institute e-newsletter *HRC Alerts*
- Nominations and votes were solicited from:
  - ECRI Institute professionals in disciplines ranging from clinical patient safety to health technology and event investigation
  - Our PSO advisory council

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How You Can Use the List

- Use as a starting point for
  - Conducting patient safety discussions
  - Setting patient safety priorities
- Determine whether
  - Your organization is facing similar issues
  - The concerns should be targeted for improvement
- Develop strategies
  - See the executive brief or full report
- Consult other ECRI Institute resources
  - Consider applications across care settings

Questions:

- Which top ten item is most important to you?
- Do you see any similar events at your hospital?
- Which top ten item should be a priority?

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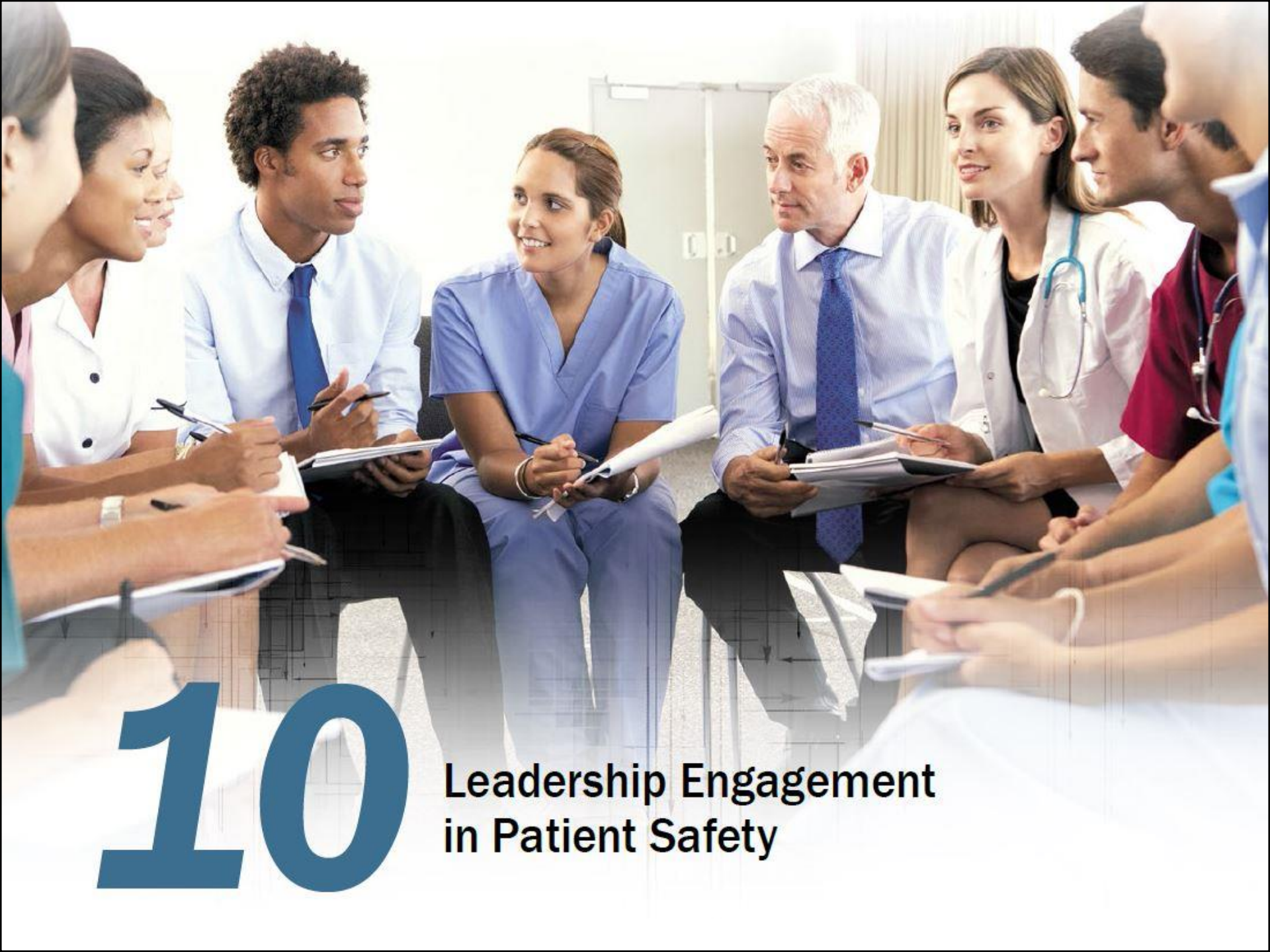

10 Leadership Engagement in Patient Safety

Example: Engagement in Event Reporting

Leadership Engagement

- Organization leadership may see increased reporting as a negative, believing that more reports indicate a higher incidence of events, safety concerns, and more. In order to change this perception, the patient safety, quality, or risk manager needs to appeal to leadership on both an intellectual and an emotional level to successfully engage them.
- The risk manager maps the organization's reporting data against its own harm reports as well as reporting data from comparable organizations, helping leaders visualize the effects of event reporting and creating a baseline by which to monitor reporting rates. The risk manager also recruits champions at various levels across the organization to help appeal to leadership.

Thoughts from Our Experts

Leadership Engagement

"It all starts with emotional and intellectual engagement. Tell some stories: 'This patient died in our organization because of a *C. difficile* infection. She didn't have it when she was admitted, and she caught it here.' Stories are powerful."

Carol Clark, BSN, RN, MJ
Patient Safety Analyst
ECRI Institute

Example Strategies

Leadership Engagement

Marshal the data

- Understand all aspects of the patient safety initiative being considered.

Recruit organization champions

- Seek champions in departments across the organization.

Connect intellectually and emotionally

- Present the data, proposal, and goals to the c-suite and board.
- Tell stories to demonstrate need.
- Be able to show return on investment.
- Show projected reduction of harm.

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9 Patient Engagement and Health Literacy

Event Reported to ECRI Institute PSO

Patient Engagement

Found patient not taking warfarin and taking aspirin. Some medicines were missing. Family and patient were very confused about discharge orders from the hospital—poor discharge planning.

Thoughts from Our Experts

Patient Engagement

“We don't do a great job of engaging patients and making sure they understand their health and healthcare, and we underestimate how often those failures lead to serious harm.”

Josi Wergin, CPHRM, CPASRM, ELS
Risk Management Analyst
ECRI Institute

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Example Strategies

Patient Engagement

Involve patients in leading change

- Integrate patient engagement and health literacy into the organization's mission, vision, and goals.
- Involve patients and families in identifying, planning, and testing changes.

Use "universal precautions" for health literacy

- Use plain language, demonstration, open-ended questions, and "teach back."
- Repeat key messages over multiple encounters and in a variety of media.
- Train and coach personnel in communication and universal precautions.

Engage patients

- Implement bedside rounds, daily goal sheets, or coaching for patients.
- Elicit patients' goals, and connect the recommended actions with those goals.
- If patients still do not adhere to the plan of care, investigate why, and address barriers.
- Tackle common barriers, such as difficulties with access and navigation.
- Partner with other organizations to address social determinants of health.

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8 Device Cleaning, Disinfection, and Sterilization

Events from the News

Device Cleaning

- In 2008, more than 10,000 patients were informed that they might have been exposed to bloodborne pathogens during colonoscopies because the endoscopy equipment and accessories had been reprocessed improperly.
- In 2013, inadequate disinfection of duodenoscopes resulted in outbreaks of carbapenem-resistant Enterobacteriaceae.

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Thoughts from Our Experts

Device Cleaning

“Once you have an outbreak, everything needs to be examined . . . this is a lot less stressful to do before we have bioburden and contaminants showing up in our trays.”

Scott R. Lucas, PhD, PE
Director of Accident and Forensic Investigation
ECRI Institute

Example Strategies

Device Cleaning

Beware bottlenecking of case carts

- Ensure that sufficient equipment and credentialed and certified staff are on hand to meet the operating room's (OR) needs.
- Schedule staff at times that correlate to the OR schedule.

Follow current guidelines and manufacturer recommendations

- Ensure that staff are well versed in device-specific manufacturer cleaning recommendations.
- Educate staff on device cleaning recommendations from the manufacturers of the sterilization devices themselves.

Check facility water and environmental filtration

- Ensure regular surveillance and maintenance of the facility's water and steam quality and filtration systems.

Make cleaning and disinfecting a team effort

- Work to foster a team environment between the OR staff and the central sterile processing staff.

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7 All-Hazards Emergency Preparedness

Events from the News

Emergency Preparedness

- In the fall of 2017, following Hurricane Irma 14 residents at a Florida nursing home died of heat-related causes after the storm knocked out the facility's air-conditioning.
- A disgruntled former employee entered a Bronx hospital with a gun in June 2017, killing one person and wounding six others, before killing himself.
- A global ransomware attack in May 2017 crippled computers across the globe, including those of the United Kingdom's National Health Service, forcing hospital staff to use pen and paper and requiring widespread cancellation of procedures.

Thoughts from Our Experts

Emergency Preparedness

“I don’t know that there’s any way to prevent any future natural disasters, or even most intentional disasters. Obviously, preparing is a whole lot better than having to recover.”

Patricia Neumann, MS, RN, MT (ASCP), HEM
Senior Patient Safety Analyst and Consultant
ECRI Institute

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Example Strategies

Emergency Preparedness

Be prepared

- Ensure that your entire organization knows that the old adage, "An ounce of prevention is worth a pound of cure," applies to both natural and intentional disasters.
- Prepare for *when,* not *if*, a disaster will occur.

Learn from the past

- Distribute best practices learned from past disasters in order to ensure mistakes are not repeated.

Have all-hazards disaster plans in place

- Use a systematic approach to conduct a hazard vulnerability assessment (HVA) or a threat and hazard identification and risk assessment (THIRA) to identify problem areas.

Conduct drills

- Coordinate with law enforcement to conduct active shooter drills and make sure staff understand the advice to “Run, hide, and fight.”

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6 Management of Behavioral Health Needs in Acute Care Settings

Event Reported to ECRI Institute PSO

Behavioral Health

An emergency department (ED) patient on psychiatric hold stated he needed to go to the bathroom. When the door was opened to let him use the bathroom, the patient ran. The patient exited through the secure door as a staff person was entering the ED. The patient ran and jumped through the window at the end of the hall, landing on the roof. The patient then jumped 18 feet to the parking lot, landing on his backside.

Thoughts from Our Experts

Behavioral Health

"Relationships and partnerships are what get you what you need."

Nancy Napolitano
Patient Safety Analyst and Consultant
ECRI Institute

Example Strategies

Behavioral Health

Assess all patients

- Perform a behavioral-health-inclusive assessment along with the medical assessment.

Train staff and develop expertise

- Train staff to work with patients with behavioral health needs, and hold frequent drills.
- Develop resources (e.g., behavioral emergency response teams, telepsychiatry access).

Create supportive environments

- Create safe spaces for patients who may harm themselves or others, such as by establishing quiet, calm environments and minimizing ligature points and improvised weapons.

Work with the community and other partners

- Engage in a dialogue with the community to identify needs.
- Work with other partners, such as psychiatrists, behavioral health treatment programs, clinics, medical schools and teaching programs, and law enforcement.

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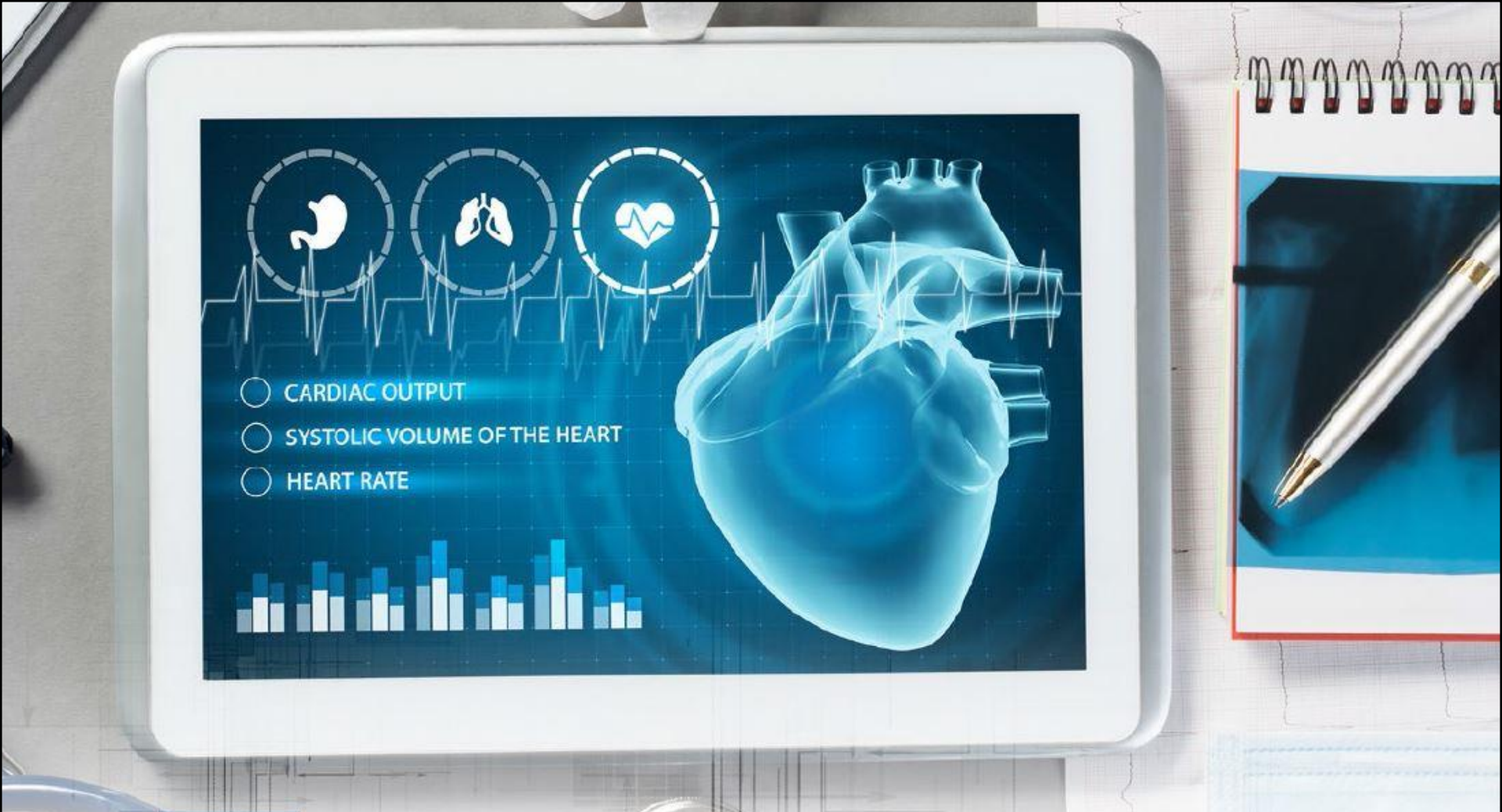

5 Incorporating Health IT into Patient Safety Programs

Event Reported to ECRI Institute PSO

Health IT

In two events, an extra medication dose was given to the patient. In each instance, the medication had been ordered as a one-time order and administered the day before the duplicate dose was received. Even though the administration of the medications was documented in the medication administration record, the documentation of this action was not readily visible to the staff.

Event Reported to ECRI Institute PSO

Health IT

A patient was transferred between hospital units. During the electronic medication reconciliation of an order for prednisone, which was being given in a tapering dose and was ordered to be continued upon transfer to the new unit of the facility, the dosing regimen was started over from the beginning. The patient received the higher dose for an extra day before this error was discovered.

Thoughts from Our Experts

Health IT

When health information technology (IT) systems are poorly designed, or when the organization's culture fails to embrace health IT safety, patients can suffer. **"It is not only how we use it in daily workflow, but also how we use it effectively by optimizing the benefits and reducing the risks."**

Robert C. Giannini, NHA, CHTS-IM/CP
Patient Safety Analyst and Consultant
ECRI Institute

Example Strategies

Health IT

Integrate health IT safety into existing risk and safety programs

- Use risk identification, risk analysis and assessment, risk mitigation, risk control, and acceptance of risk to identify health-IT-related risks, hazards, and events.
- Use self-assessments to ensure that your health IT safety program is designed effectively.

Collaborate with stakeholders

- Share information on health-IT-related events with stakeholders and throughout the organization.
- Incorporate elements into staff training and ongoing education that can help staff recognize and address health IT safety concerns and identify links between the technology they're using and events that might occur.

Embed health IT into the organization's culture

- Work toward creating a culture that prioritizes safety, encourages staff to speak up when they see a problem, and provides resources to help staff better recognize and avoid health IT issues.

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4 Workarounds

Event Reported to ECRI Institute PSO

Workarounds

A severely agitated patient arrived on the unit as a direct admission from another hospital. The patient's behavior was dangerous, and staff safety was in jeopardy. The patient had not been registered in the computer system. The doctor on the unit had ordered "stat" medications for severe agitation and anxiety. Because the patient was not in the system, I removed the medications from the automated medication dispensing cabinet by override.

Event Reported to ECRI Institute PSO

Workarounds

To help expedite transfer of a coworker's patient to emergency surgery, I agreed to give medication to the patient. I hurried to the bedside and did not scan or check the patient's band. Unfortunately, this caused me to give medication to the wrong patient.

Thoughts from Our Experts

Workarounds

Workarounds get passed from one staff member to another.

“We hear, ‘It’s the way we do things here.”

Kelly C. Graham, RN
Patient Safety Analyst and Consultant
ECRI Institute

Example Strategies

Workarounds

Talk to staff

- Identify workflow issues contributing to workarounds by encouraging staff to speak up about them.
- Promote an open, nonpunitive environment where staff feel at ease speaking up.

Conduct a gap analysis

- Look at policies and processes as written and compare them with what is really occurring.
- Understand why the gaps exist and how best to match processes and workflow.

Match policy and practice

- Seek staff input on draft policies and procedures to determine whether the described approach is feasible and to address any barriers.

Maintain technology

- Ensure that an ongoing maintenance plan is in place for technology to perform reliably.
- Conduct periodic reviews of reports provided by a system (e.g., overrides of dispensing cabinets) to uncover workflow inefficiencies and opportunities to reinforce training in important practices.

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3 Internal Care Coordination

Event Reported to ECRI Institute PSO

Internal Care Coordination

A patient was transferred to the intensive care unit and was massively bleeding. There was a delay in activation of the exsanguination protocol. There was also a delay in recognizing hypotension due to lack of attention paid to blood pressure (BP) and heart rate. Closer attention to BP and heart rate were needed with more timely and aggressive initiation of blood transfusion.

Thoughts from Our Experts

Internal Care Coordination

“Many handoff tools are available to ensure the vital information is communicated and the process is standardized.”

Elizabeth Drozd, MS, T (ASCP) SBB, CPPS
Senior Patient Safety Analyst
ECRI Institute

Example Strategies

Internal Care Coordination

Train providers to communicate better

- Foster a healthcare culture in which providers are taught communication skills, beginning in medical or nursing school (and in other providers' training).
- Continue this process once they enter the workforce through educational techniques, such as simulation training.

Convey all necessary information at each step

- Ensure that providers are aware that conveying complete and correct information about a patient, including medical history and what medications he or she is taking, at each step in the care process is essential.

Use safety communication tools

- Promote use of tools such as checklists, huddles, and repeat-back techniques to simplify handoff processes and improve communication.

Provide leadership support

- Support the organization's care coordination efforts by encouraging providers to communicate, assess patient needs, and coordinate with other specialists.

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2 Opioid Safety across the Continuum of Care

Event Reported to ECRI Institute PSO

Opioids

The patient's boyfriend brought heroin into the hospital. The patient injected half a bag of heroin through her peripherally inserted central catheter. The patient went into cardiac arrest and was transferred to the coronary care unit. Cardiopulmonary resuscitation was started, and she was put on a ventilator. She was weaned off the ventilator rather rapidly.

The next day, the patient felt fine and showed normal sinus rhythm, so she was transferred back to the floor. She stated she injected the heroin because she was embarrassed to ask for pain medications because she thought the staff would judge her.

Event Reported to ECRI Institute PSO

Opioids

Patient was given intravenous (IV) morphine, IV lorazepam, and oral hydrocodone/acetaminophen at same time in ED. Patient was extremely lethargic and difficult to arouse. Vital signs stable. Will monitor. Charge nurse, night nurse, and MD were made aware.

Thoughts from Our Experts

Opioids

“It’s a patient safety concern because of the seriousness of the side effects.”

Stephanie Uses, PharmD, MJ, JD
Patient Safety Analyst and Consultant
ECRI Institute

Example Strategies

Opioids

Assess and educate patients

- Assess patients comprehensively, including assessment for opioid use disorder.
- Educate patients on how to properly use, secure, and dispose of medications.
- Set realistic expectations regarding pain.

Rethink pain management

- Favor multimodal therapy, nonpharmacologic modalities, and nonopioid pain medications.
- Write clinical decision support to account for opioid tolerance and risk factors.

Monitor patients effectively

- Use sedation scales that incorporate nurse-driven protocols to monitor patients.
- Continuously monitor patients on parenteral or neuraxial opioids for at least the first 24 hours.

Partner to help treat opioid use disorder

- Investigate ways to initiate treatment or engage patients before they leave.

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1 Diagnostic Errors

Event Reported to ECRI Institute PSO

Diagnostic Errors

The patient presented with abdominal pain and was admitted but then discharged home. Several days later, she presented to the ED. She had a ruptured appendix with a large abscess. She was brought to the pediatric intensive care unit, where her many serious diagnoses included septic shock, respiratory failure, and fluid in the lungs.

Thoughts from Our Experts

Diagnostic Errors

“It’s a multifactorial problem. Diagnostic errors are the result of cognitive, systemic, or a combination of cognitive and systemic factors.”

Gail M. Horvath, MSN, RN, CNOR, CRCST
Patient Safety Analyst and Consultant
ECRI Institute

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Example Strategies

Diagnostic Errors

Leverage tools and technologies

- Use tools (e.g., algorithms) to aid in making a diagnosis or distinguishing diagnoses.
- Employ technologies or health IT solutions that aid diagnosis.

Capture diagnostic errors and near misses

- Capture data using a variety of sources.
- Extend reporting and improvement systems to all settings.

Learn and improve

- Establish a nonpunitive culture that supports learning and open discussion.
- Begin an ongoing quality initiative to tackle diagnostic errors throughout the organization.
- Analyze the data, and make changes to address gaps.
- Discuss the topic in multiple forums (e.g., staff education, grand rounds).

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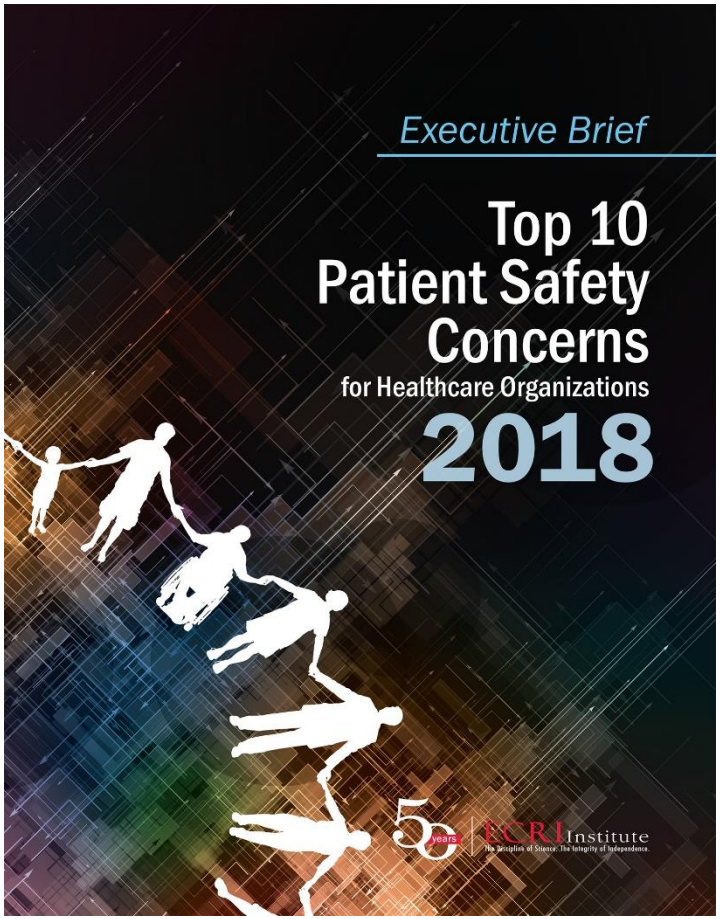
How to Get the Report



HRC and PSO members can access the full report by logging in at www.ecri.org

Nonmembers can access an executive brief of the report at www.ecri.org/patientsafetytop10

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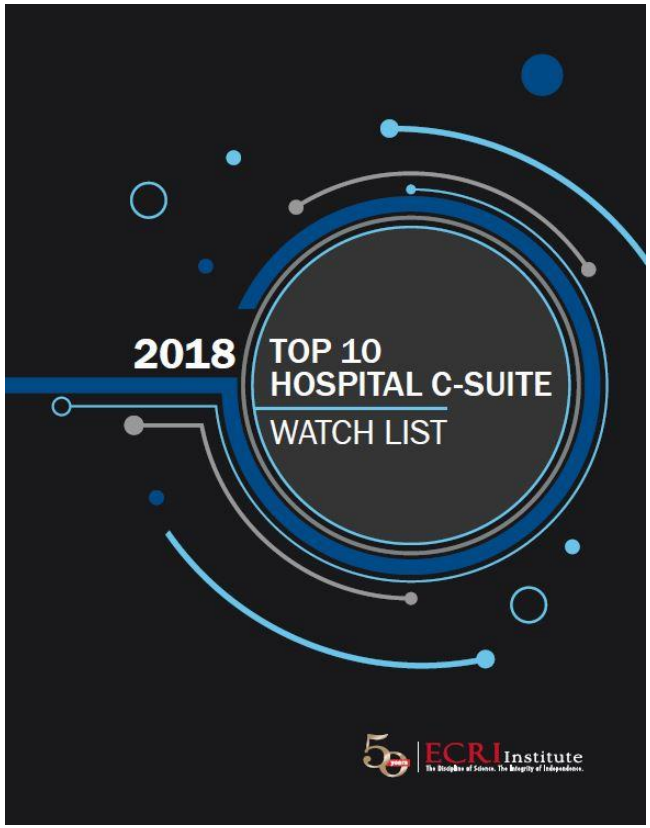
ECRI Institute's Other Top 10 Reports

www.ecri.org/2018hazards



www.ecri.org/2018watchlist

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Next PSO Webinar:

Discharge Documents: How Well Do They Support Care Coordination?

Thursday, July 19, 2018
1:30-2:30pm (Eastern Time)

Questions?

Thank You